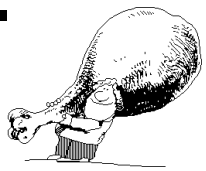
Claims Clues



A Publication of the AHCCCS Claims Department November, 1998

New KidsCare Program to Begin November 1

KidsCare, the popular name for AHCCCS' new Title XXI Child Health Insurance Program, is scheduled to go into effect with dates of service beginning November 1.

The program provides health care coverage to targeted low-income children under the age of 19 if the family income falls within the following thresholds:

- 150 per cent of federal poverty level (FPL) beginning Nov. 1, 1998
- 175 per cent of FPL beginning July 1, 1999
- 200 per cent of FPL from July 1, 2000, through Sept. 30, 2007

KidsCare applicants also will be screened for Medicaid (Title XIX) eligibility. Medicaid eligibility will override KidsCare eligibility.

KidsCare eligibility is always prospective, meaning there is no retro-eligibility period.

A child determined eligible for KidsCare will be guaranteed a one-time 12 months of continuous coverage.

Eligibility is redetermined annually for 12-month periods unless the member no longer meets KidsCare eligibility criteria.

Services are provided through AHCCCS-contracted health plans, through the state employee health maintenance organizations (HMOs) who elect to participate in the program, and the Department of Health Services (DHS) Direct Services Program. Each recipient has a choice of available contractors and primary care providers in the recipient's Geographic Service Area.

Native American recipients may also elect to receive services through Indian Health Service (IHS) or 638 tribal facilities.

Claims for services provided to KidsCare recipients enrolled with one of the AHCCCS health plans, state employee HMOs, DHS Direct Services, or Regional Behavioral Health Authorities (for behavioral health services) must be billed to that contractor.

Claims for services provided to KidsCare recipients enrolled with IHS or 638 tribal providers must be billed to AHCCCS.

The KidsCare service package is as nearly as practical the same service package offered to state employees by the least expensive commercial HMO.

Dental and vision services have been added for KidsCare children.

Behavioral health/substance abuse services (combined) are limited to 30 days of inpatient services per contract year (11/01-09/30 for 1998-99, 10/01-09/30 for all other years).

Each day of partial care, basic or intensive, counts as ½ day of inpatient care. Each half-day of partial care, basic or intensive, counts as ¼ day of inpatient care.

Outpatient behavioral health/substance abuse services (combined) are limited to 30 visits per contract year.

Each outpatient service except group therapy or group counseling counts as one visit. Each group therapy or group counseling service counts as ½ outpatient visit.

Vision examinations for prescriptive lenses and/or the provision of a set of prescriptive lenses are limited to one per contract year.

Certified and licensed nurse midwife prenatal or home delivery services are not covered for KidsCare recipients. Non-emergency transportation and chiropractic services also are not covered.

DHS Direct Services has a separate coverage package that excludes certain services, including behavioral health and emergency care, but includes non-emergency transportation. ❒

We're on The Web

Claims Clues is now available on the AHCCCS Web site on the Internet.

The Internet address for the AHCCCS home page is www.ahcccs.state.az.us.

To view recent issues of *Claims Clues*, select Resources, then Publications, then Guides & Manuals.

The Web site provides information about AHCCCS programs and services, including KidsCare. ❒

Open Enrollment Becomes Annual Enrollment

AHCCCS open enrollment has changed from a once-a-year event occurring in August to an on-going process.

Recipients now may change health plans once a year during their enrollment anniversary month. The enrollment anniversary is the month in which a recipient was enrolled with an AHCCCS health plan.

If more than one person in a household is on AHCCCS, that household's anniversary will be the month in which enrollment occurred for the recipient who has been enrolled for the longest period of time. Any member of the household who wants to change plans may do so at the same time. All AHCCCS recipients have been assigned an anniversary date.

The new process began on July 1 for households with a September anniversary date.

Two months prior to their anniversary date, recipients will be mailed information about the available health plans in their county. Those who wish to change plans will have a month to notify AHCCCS of their decision.

The following month will be the transitional month during which time AHCCCS notifies both the former plan and new plan of the enrollment changes.

This process will allow the plans adequate time to transfer records and welcome new members due to the smaller volume of members transitioning each month.

Recipients may change their health plans by mail or by calling AHCCCS with their enrollment choice. As in the past, recipients who do not want to change health plans do not have to do anything, and they will remain enrolled in their current health plans. ❒

Plastic ID Cards Distributed to Recipients

AHCCCS has begun distributing new plastic identification cards to more than 400,000 recipients.

The plastic cards will replace the six different AHCCCS paper ID cards now in use.

A magnetically encoded strip on the card will enable providers to "swipe" the card through a card reader and obtain eligibility and enrollment information, similar to the way consumers use credit and debit cards in stores.

Because the new card will access recipient files in the AHCCCS system, the most current eligibility and enrollment information always will be available to providers.

Beginning in late June, AHCCCS conducted a series of "Vendor Fairs" throughout the state to introduce providers to the new swipe card technology.

Representatives of the three vendors who were awarded contracts for MEVS (Medical Electronic Verifications Systems) -- The Potomac Group, CSA, and Envoy -- accompanied AHCCCS representatives to each of the 19 fairs. Approximately 1,300 providers attended these fairs.

As a result of provider feedback from the Vendor Fairs, the name of the recipient's health plan will be listed on card along with the recipient's name and ID number.

Recipients will be advised that the ID card is a permanent card that they must carry at all times.

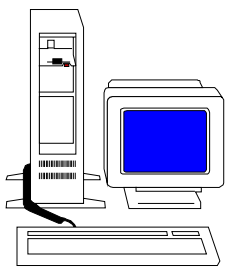
Providers seeking information on MEVS may contact any or all of the three vendors at:

CSA	1-800-232-2345
Envoy	1-800-366-5716
Potomac:	1-800-444-4336 ❒

Agency Expects Y2K Compliance by June 30, 1999

AHCCCS intends to be fully Year 2000 compliant by June 30, 1999.

According to Tim MacDonald, applications manager in the agency's Information Systems Division, compliance for Year 2000 processing is defined as "having all necessary hardware, network configuration, system software, and applications software validated to ensure that neither system performance nor business functionality is affected by dates prior to, during, and beyond the year 2000."



MacDonald said this assessment includes not only hardware and software but also internal and external system interfaces.

Questions regarding AHCCCS' Year 2000 compliance can be addressed to MacDonald at (602) 417-5935 or via e-mail to tamacdonald@ahcccs.state.az.us. ❒

Coding Corner

The AHCCCS Administration has made the following changes to its Reference subsystem:

- The following replacements were effective 01/01/98:
  G0051 replaced by 17000
  G0061 replaced by 32491
  G0083 replaced by 90816
  G0084 replaced by 90817
  G0085 replaced by 90818
  G0086 replaced by 90819
  G0087 replaced by 90821
  G0088 replaced by 90822
  G0089 replaced by 90823
  G0090 replaced by 90824
  G0091 replaced by 90826
  G0092 replaced by 90827
  G0093 replaced by 90828
  G0094 replaced by 90829
- The following codes were endated effective 09/30/98:
  W0087
  W0088
  W0089
- The following codes have been added to the list of allowable behavioral health diagnosis codes:
  332.1, 333.1, 333.7, 333.82, 33.90, 333.92, 33.99, 347, 607.84, 608.89, 625.0, 625.8, 780.09, 780.52, 780.54, 780.59, 780.9, 787.6, 799.9, 995.2, 995.5, 995.81, V61.10, V61.12, V61.21, V61.9, V62.4, V62.83, V71.01

Provider type 07 (Dentist)

- Add 99211 – 99213 effective 01/01/96

Provider type 08 (Physician)

- Add G0050 effective 01/01/96

Provider type 09 (CNM)

- Add 56501 effective 01/01/98

Provider type 31 (Osteopath)

- Add 87087 effective 01/01/96

Provider type 43 (ASC)

- Add A4300 effective 09/01/93
- Add V2785 effective 01/01/98
  NOTE: These codes are reimbursed according to the capped fee schedule rather than at one of the eight ASC levels. ❒

Labs May Not Bill Tests Included in Dialysis Rate

Laboratory claims for diagnostic tests for dialysis recipients should not be billed to the AHCCCS Administration when the tests are covered under the composite rate paid to dialysis facilities for treatments.

Tests for which reimbursement is not included in the composite rate or which are performed more frequently than specified in the composite rate are separately billable to AHCCCS.

Documentation of medical necessity may be required for some tests before payment is made. Documentation is always required if tests are conducted in excess of weekly or monthly limits set by Medicare.

Hematocrit or hemoglobin and clotting time tests furnished incident to dialysis treatments are always covered in the composite rate. Prothrombin time, serum creatinine and BUN tests are reimbursed under the composite payment if furnished weekly or less often.

The following tests are covered in the composite payment if furnished monthly or less often:

Serum Calcium, Serum Chloride, Total Protein, CBC, Serum Bicarbonate, Serum Phosphorous, Serum Albumin, Alkaline Phosphatase, SGOT, LDH, Serum Potassium.

If any of these tests are performed more frequently than specified, the additional tests may be billed separately. These tests may be covered by AHCCCS only if medically justified by supporting documentation. ❒

Cover Sheet Needed When Faxing PA Information

Providers who fax documentation to the AHCCCS Prior Authorization Unit should ensure that a cover sheet accompanies the documentation.

The cover sheet should list provider's name and AHCCCS provider ID number, the name of a contact person, a telephone number and a fax number.

This will enable an AHCCCS PA nurse to contact the provider in case additional information or clarification is needed before services can be authorized.

Without such information, authorization may not be established, and claims may be denied.

The PA Unit's fax number is (602) 256-6591. ❒

Providers Must Clearly Identify Resubmissions

Providers must clearly identify resubmissions of denied claims and adjustments and voids of paid claims in order for the AHCCCS claims system to correctly reprocess the claims.

The claim reference number (CRN) of the original claim *must* be included to enable the AHCCCS system to identify the claim being adjusted, resubmitted, or voided. If a claim is not identified as a resubmission, it will be entered as a new claim and denied as a duplicate.

When resubmitting a denied claim or adjusting a paid claim, the provider should resubmit the claim in its entirety. If any previously paid lines are blanked out, the AHCCCS system will assume that those lines should not be considered for reimbursement, and any payment will be recouped.

Here are the guidelines for resubmitting, adjusting, and voiding fee-for-service claims submitted to AHCCCS.

HCFA 1500 Claims

To resubmit a denied HCFA 1500 claim, providers must enter "A" in the "Medicaid Resubmission Code" section and the original CRN in the "Original Ref. No." section of Field 22.

The provider should resubmit the claim in its entirety, including any paid lines.

Example:

Provider submits a three-line claim. Lines 1 and 3 are paid, but Line 2 is denied. The provider should resubmit all three lines. If only Line 2 is resubmitted, payment for Lines 1 and 3 will be recouped.

To adjust a denied HCFA 1500 claim, providers must enter "A" in the "Medicaid Resubmission Code" section and the original CRN in the "Original Ref. No." section of Field 22.

The provider must submit the adjusted claim in its entirety, including new claim line(s) if applicable as well as any line(s) not being adjusted.

Example:

Provider submits a three-line claim. All three lines are paid. The provider discovers an error in the number of units billed on Line 3 and submits an adjustment. The provider should resubmit all three lines. If only Line 3 is resubmitted, payment for Lines 1 and 2 will be recouped.

To void a claim, providers must enter "V" in the "Medicaid Resubmission Code" section and the original CRN in the "Original Ref. No." section of Field 22.

The provider must enter only the claim line(s) to be voided and cross out all other lines. If a line is not crossed out, the line will be voided and payment recouped.

UB-92 Claims

To resubmit a denied UB-92 claim, providers must write the word “Resubmission” and the CRN of the denied claim in the “Remarks” field (Field 84).

To adjust a paid UB-92 claim, providers may use bill type XX6 and write the CRN of the paid claim to be adjusted in Field 84. Providers also may write the word “Adjustment” and the CRN of the claim to be adjusted in Field 84.

To void a UB-92 claim, providers must use bill type XX7 and enter the CRN of the claim to be voided in Field 84.

If Field 84 is used for other purposes, providers should write resubmission or adjustment information at the top of the claim form. ❒

Midwife Must Be Surgical 1st Assistant to Aid with Cesarean

Certified nurse midwives (Provider Type 09) and registered nurse practitioners (Provider Type 19) must also be certified as surgical first assistants in order to bill for assisting during a cesarean delivery.

Claims for assisting during a cesarean delivery from non-physician providers who are not certified as surgical first assistants are subject to denial.

Modifier 80 must be used to indicate the assist. ❒

Bed Hold Days Require Case Manager Authorization

Case manager authorization is required order for nursing facilities to bill the AHCCCS Administration for bed hold days for ALTCS recipients.

Therapeutic bed hold days (revenue code 183) are limited to 9 days per contract year (10/01-09/30). Bed hold days (revenue code 185) are limited to 12 days per contract year.

If a case manager authorizes bed hold days that exceed these limits, claims for days exceeding the limits will not be paid, even though the authorization may be valid.

Revenue code 183 is authorized for a home visit by the recipient. Revenue code 185 is authorized when short-term hospitalization is medically necessary. ❒